Instructor Scenario Sheet

Group Testing - Case 1: Shoulder Dystocia

Assigned Team Leader Name: ____

Instructor reads scenario introduction: “A 34-year-old Gravida 1 Para 0 at 41 2/7 weeks’ estimated gestational age presents in spontaneous labor with an unremarkable prenatal history significant only for a pre-pregnancy history of morbid obesity. This person has progressed to the second stage of labor and labored down for 3 hours, but the fetal vertex remained at 0 station. With pushing, the fetal head has rotated and descended slowly with each push but returned to +2 station between contractions. In the last contraction, the fetal head looked like it was about to deliver. Hold a 1-minute team huddle to prepare for this situation.”

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster)

After team brief, Instructor adds: “With the next push, the fetal head delivers. After 30 seconds of more than adequate attempts to deliver the anterior shoulder, there is no delivery of the anterior shoulder. What do you do now?”

Instructor note: The instructor should not allow the infant to deliver after only the McRoberts maneuver and suprapubic pressure are performed; however, may allow delivery following any of the remaining interventions.

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes this step in the mnemonic, the instructor may use the following prompts as needed:	Expected safety behaviors:
H = Call for **H**elp early	• What extra personnel do you need?	Call for: ☐ Extra nurses ☐ Newborn resuscitation team ☐ Anesthesia ☐ Surgical backup personnel
E = Evaluate and **E**xplain (which shoulder is anterior/assign roles to your team)	• Following brief explanation to patient, family, and team of shoulder dystocia; instructor says “30 seconds pass without delivery”	☐ Team prepares for McRoberts and suprapubic pressure
L = Elevate **L**egs for McRoberts maneuver	• After McRoberts, there is still no delivery	☐ Staff assist in performing McRoberts Maneuver
P = Directs others to perform suprapubic **P**ressure (indicate which direction the pressure is applied) continuous, then 'rocking'	• Suprapubic pressure is performed, but there is still no delivery	☐ Staff assist in performing suprapubic pressure
E = Consider **E**pisiotomy	• You decide you have plenty of room to perform internal enter maneuvers and do not cut an episiotomy at this point	☐ Episiotomy is considered but decided against

R^4 = **R**emove the Posterior Arm *R's may be attempted in any order	• After successful removal of the posterior arm, there is still no delivery. What else can be performed to deliver the infant?	☐ Verbalizes maneuvers to sweep and deliver the posterior arm
R^4= **R**otatory internal maneuvers	• None of these maneuvers result in delivery • What else can be done? (only prompt if student does not spontaneously state)	☐ Enter perineum to perform maneuvers ☐ Verbalizes all enter maneuvers • Rubin II • Rubin II + Woods Screw • Reverse Woods Screw
R^4 = **R**oll the patient (Gaskin maneuver)	• This alone also does not deliver the infant • What else can be done? (only prompt if student does not spontaneously state)	☐ Instructs team to "rotate patient" to hands and knees position ☐ Team members assist as needed ☐ Verbalize that maneuvers may be repeated if delivery does not occur and additional maneuvers tried - Posterior sling - Zavanelii - Symphysiotomy
R^4 = **R**epeat all maneuvers		

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes

☐ No

Case conclusion: "After all efforts, anterior shoulder and fetal body delivers. Newborn is dried, stimulated, and suctioned. The infant requires 2 minutes of positive pressure ventilation after which the newborn has a pulse rate >100 BPM, cries, turns pink, and flexes all extremities."

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐ Passed

☐ Needs remediation

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(Instructor Signature)

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(Instructor Printed Name)

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(Date)

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Instructor Scenario Sheet

Group Testing - Case 2: Third-Trimester Bleeding

Assigned Team Leader Name: ____

Instructor reads scenario introduction: "A 25-year-old Gravida 2 Para 1 at 35 weeks' gestation with vaginal bleeding arrives at triage via ambulance. It is estimated that the pregnant person has lost approximately 450 mL total in home and ambulance thus far. On arrival continuous electronic fetal monitoring is applied. Hold a 1-minute brief to prepare for this situation."

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster). After team brief, Instructor repeats introduction and encourages progression of scenario.

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes, Instructor says:	Expected safety behaviors:
Overall Assessment and Interventions	• What are the important points you must consider?	☐ Obtains blood type and Rh status (Rh_o[D] immune globulin will be needed if the woman is Rh negative) ☐ Presence or absence of contractions ☐ Obtains history (ensures no history of placenta previa); gentle speculum examination after confirming no history of previa ☐ Considers potential causes of bleeding (eg, trauma, illicit drug use such as cocaine)
Fetal Assessment and Interventions	• Continuous electronic fetal monitoring shows a Category 1 fetal heart rate (FHR) tracing (baseline 140 BPM, moderate variability, no decelerations). Placenta previa is ruled out by reviewing the available prenatal records, which state there is a fundal placenta. Blood type (O positive) is also noted in the record. • Two contractions occur over 20 minutes and are visible on FHR tracing. Speculum examination confirms continued, bright red vaginal bleeding. Approximately 150 mL of additional blood loss is noted and total blood loss is now approximately 600 mL.The cervix is closed. • How will you manage this case?	☐ Evaluates continuous fetal monitoring (fetal heart rate [FHR] Category 1,2, or 3 plus presence or absence of contractions) ☐ Consults obstetric surgeon (family medicine-obstetrics or obstetrics-gynecology specialist) and anesthesia staff

		☐ Obtains type and cross (2 units packed red blood cells [PRBC]), disseminated intravascular coagulation panel +/, urine toxicology testing ☐ Administers intravenous fluid bolus in preparation for transfer to an operating room, given the need to expedite delivery despite a closed cervix and being remote from delivery
	Over time, EFM reveals minimal variability and the baseline FHR increases to 170 BPM. Late decelerations are noted. The frequency of contractions increases to every 5 to 7 minutes. The person is reporting continuous abdominal tenderness. • What is the diagnosis and how will you proceed?	☐ Evaluates fetal and uterine status ☐ Cesarean delivery is called for placental abruption ☐ Considers starting PRBC transfusion if bleeding continues

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes
☐ No

Case conclusion: "A viable newborn is delivered via cesarean delivery. A large amount of blood is visualized behind the placenta after delivery, confirming abruption. The birthing person's blood pressure remained normal during and after delivery."

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐ Passed

☐ Needs remediation

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(Instructor Signature)

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(Instructor Printed Name)

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(Date)

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Instructor Scenario Sheet

Group Testing - Case 3: Postpartum Hemorrhage

Team Leader Name: ____

Instructor reads scenario introduction: "An 18-year-old Gravida 1 Para 0 at 40 weeks 2 days' estimated gestational age with a macrosomic fetus was admitted with prelabor rupture of membranes. The patient has been receiving oxytocin for more than 24 hours and is receiving ampicillin and gentamicin intravenously for chorioamnionitis. Hold a 1-minute team huddle to discuss how to prepare for delivery."

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster)

After team brief, Instructor adds: "The patient delivers the fetal head suddenly. Before you can get gloves on, the fetus delivers. What could be done next to prevent complications?"

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes, Instructor says:	Expected safety behaviors:
Active Management of the Third Stage of Labor (AMTSL)		☐Performs all aspects of AMTSL: ☐Administer oxytocin 10 U intramuscularly (IM) or intravenous (IV) equivalent ☐Hold gentle traction on cord ☐Delay cord clamping if infant does not need immediate assistance ☐Perform transabdominal massage following delivery of the placenta
	• Delivery of placenta is followed by a large amount of bleeding • What do you do now?	☐Performs bimanual uterine massage while directing team to perform CAB (circulation, airway, breathing) ☐Obtains IV access with 2 large-bore IVs ☐Begins quantitative blood loss by assessing volume in the under-buttocks drape and/or requesting serial weight measurement of blood-stained pads, gauze, laps, etc.

Initiation of the Four Ts **T**one *Note: The group can be tested on institution-specific drug protocols and dosages for postpartum hemorrhage management (eg, oxytocin protocols) when appropriate (If all participants are from same center)*	• Initial QBL is 500mL • What are you looking for when you say tone? • After using all drugs, you see that bleeding continues	☐Verbalizes drug dosages and routes: oxytocin—30IU in 500 mL NS, infuse 167 mL over 10 min then 90-200 mL/hr. Can increase up to 80 IU/L if needed • Methylergonovine (0.2 mg IM; contraindicated in women with hypertension) • Misoprostol (600 mcg sublingually or 800 mcg rectally)15-methyl • Prostaglandin F2-alpha (0.25 mg IM)Tranexamic acid 1 g in 100 mL NS IV over 10 minutes ☐Notes if massage stopped inappropriately and directs team to continue
Trauma	• What are you looking for and how would you address trauma? • You see no bleeding lacerations or hematoma • QBL is now 1000 mL	☐Explore vagina, vulva, and cervix for bleeding lacerations ☐Performs thorough examination for lacerations
Tissue	• Part of the placenta is missing and the patient is not receiving epidural analgesia	☐Explores uterus for retained tissue ☐Performs manual removal of retained tissue fragment ☐Proactive preparation for regional or general anesthesia in tissue exploration/removal ☐Advocate for adequate pain control
Thrombin	• No personal or family history of bleeding disorder. Patient is still bleeding vaginally, and is now oozing from her IV sites • QBL is 1700 mL and patient is hypotensive, pale, and has tachycardia	☐ Obtains laboratory tests for "thrombin" (consider CBC, PT, PTT, INR, fibrinogen and others depending on availability at your institution) ☐ Perform bedside clot test by looking at clot tube while awaiting coagulation study results ☐ Initiate massive transfusion protocol and administer blood products

Procedural interventions	• Bleeding continues despite appropriate measures • What other interventions may be used as a last resort?	☐ Perform uterine packing ☐ Balloon tamponade of JADA insertion (Recognition that balloon tamponade, JADA or uterine packing may be unsuccessful and surgical plan should be developed) ☐ Surgical intervention with timely notification of surgical provider backup and operative team ☐ Recognition of potential surgical options including dilation and curettage for retained tissue, B-Lynch procedure, uterine artery ligation, or hysterectomy

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes

☐ No

Case conclusion: "After massive transfusion protocol is implemented, the patient stabilizes. Patient is monitored for 24 hours in the intensive care unit and discharged home 2 days later in stable condition."

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐Passed

☐Needs remediation

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(Instructor Signature)

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(Instructor Printed Name)

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(Date)

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Instructor Scenario Sheet

Group Testing - Case 4: Emergency Vaginal Breech

Scenario Assigned Team Leader Name: ____

Instructor reads scenario introduction: "A 19-year-old Gravida 2 Para 1 at 37 weeks' estimated gestational age presents to the triage area of the labor and delivery department with painful abdominal cramping. She has copious amounts of meconium per vagina. On vaginal examination, you discover the fetus is not vertex. Hold a 1-minute team brief to prepare for this situation."

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster).

After team brief, Instructor adds: "The patient has the urge push. What do you do now?"

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes, instructor says:	Expected safety behaviors:
Check for: • Full dilation • Fetal presentation • Cord prolapse	• Fetus is in breech presentation with palpable buttocks • Patient is fully dilated • Neither umbilical cord nor feet are palpated • You have no anesthesia, operating room (OR) nurse, or scrub technician	☐ Counsels patient about options ☐ Checks fetal heart rate (FHR) status ☐ Obtains intravenous (IV) access ☐ Requests ultrasound ☐ Transfers to OR if there appears to be adequate time
Ask for Help **A**wait Umbilicus Maintain Sacrum **Anterior**	• You have no anesthesia, OR nurse, or scrub technician • Buttocks are slowly *rumping* and you visualize the umbilicus • Traction is not applied • Position is sacrum anterior • FHR baseline 140 BPM with variables to 90 BPM for 20 seconds with pushing	Calls for: ☐ Extra nurses ☐ Piper forceps ☐ Newborn resuscitation (in place of neonatal) team ☐ Anesthesia with IV nitroglycerin available ☐ Surgical backup personnel
Rotate for Arms if needed	• Arms are not delivering. How do you deliver when there are nuchal arms?	☐ Demonstrate rotational maneuvers ☐ Delivers arms (sweep across face)
Enter for Mauriceau-Smellie-Veit Maneuver (MSV)	• How do you know it's time to deliver head? • What if your hand cannot fit inside the birth canal?	☐ Verbalize nape of neck observed prior to enter maneuver ☐ Allow infant to dangle 20 to 30 seconds if nape not seen ☐ Consider episiotomy (usually not needed)

Flex Head	• Where are your hands positioned? • Hand on occiput/hand on maxilla • What if head becomes entrapped? • Assess if barrier is cervix not fully dilated or pelvic bones	☐ Team member applies suprapubic pressure if asked ☐ Team member offers to elevate infant's trunk with blanket sling If head entrapment: ☐ Cervical entrapment • Nitroglycerin or cervical incisions ☐ Pelvic bone entrapment • Piper forceps (may describe heroic maneuvers of symphysiotomy or abdominal rescue [cesarean delivery after breech, Zavanelli maneuver])
(Back) **U**p (Sacrum Anterior)	• Breech infants typically present and deliver sacrum anterior. If not sacrum anterior when delivered to umbilicus, what would you do?	☐ Hands on bony pelvis for delivery after umbilicus, and if needed to rotate to sacrum anterior ☐ Position of sacrum should be observed throughout delivery and rotation accomplished before delivery of arms ☐ Maintain sacrum anterior
Lift Baby Onto Mother	• What kind of resuscitative measures might be performed for a breech delivery?	☐ Allow delayed cord clamping if appropriate ☐ Acknowledge high increased likelihood of low Apgar scores and need for resuscitative efforts ☐ Team assists with resuscitation if needed

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes

☐ No

Case conclusion: "The newborn delivers vaginally and is dried, stimulated, and suctioned. The newborn initially has decreased tone, heart rate of 80 BPM, and apnea; however, this rapidly resolves with a brief period of positive pressure ventilation and the newborn is placed on the mother's chest."

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐Passed

☐Needs remediation

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(Instructor Signature)

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(Instructor Printed Name)

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(Date)

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Instructor Scenario Sheet

Group Testing - Case 5: Eclampsia

Assigned Team Leader Name: ______________________________

Instructor reads scenario introduction: “A 21-year-old Gravida 1 Para 0 at 39 5/7 weeks’ estimated gestational age was admitted to the labor and delivery department in active labor 4 hours ago. One hour ago you performed a cervical exam after a spontaneous rupture of membranes (SROM) and noted a dilation of 8cm. There have been a couple of systolic blood pressure (BP) measurements of approximately 150 mm Hg, which have been attributed to pain. The patient now reports having a severe headache. Hold a 1-minute team brief to prepare for this situation.”

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster).

After team brief, Instructor adds: “You are called to the room because the pregnant person suddenly became unresponsive and is reportedly shaking. What do you do?”

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes, instructor says:	Expected safety behaviors:
Help Requested	• What additional personnel do you need?	Calls for: ☐ Extra nurses ☐ Newborn resuscitation team ☐ Obstetric backup ☐ Anesthesia
Protect and Monitor the Patient	• What else would you do? Assess fetus (fetal heart rate is 140 BPM) Determine type of seizure and assess history of epilepsy	☐ Protects airway ☐ Places woman in rescue position on left side to drain secretions ☐ Suctions secretions ☐ Administers oxygen ☐ Positions padded side rails ☐ Assesses length of seizure ☐ Obtains frequent vital signs ☐ Obtains intravenous (IV) access ☐ Obtains STAT laboratory tests
Administer Drugs	• What drug do you order initially? • The BP is now 170/110 mm Hg. Now what do you do initially? • After remeasuring BP, the BP level is 176/112 mm Hg. Now what do you do? • Alterative drug if needed prior to intravenous access	☐ Administers magnesium sulfate 6 g bolus IV over 10 minutes, then maintenance rate of 2 g/hour ☐ Remeasures BP to confirm severe range ☐ Administer antihypertensives ☐ Administer initial dose of labetalol 20 mg IV, initial dose of hydralazine is 5 mg IV (learner may verbalize repeated drugs [not required]) ☐ Administer immediate release or nifedipine 10 to 20 mg orally

Delivery Plans	• What information is needed to make delivery plans? • Does the patient need a cesarean delivery right now? • Patient has another seizure. Now what do you do?	☐ Assess for dilation after seizure ☐ No. Cesarean delivery is reserved for usual obstetric reasons or inability to resolve recurrent seizures. Are there adequate contractions? Augment labor with oxytocin if needed ☐ With second seizure, rebolus with magnesium sulfate 2 g IV

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes

☐ No

Case conclusion: "Patient does not have any additional seizures after the second bolus of magnesium sulfate. The patient progresses to a vaginal delivery of an infant with Apgar scores of 7 and 9."

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐ Passed

☐ Needs remediation

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(Instructor Signature)

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(Instructor Printed Name)

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(Date)

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Instructor Scenario Sheet

Group Testing - Case 6: Cord Prolapse

Assigned Team Leader Name: ____

Instructor reads scenario introduction: "A 28-year-old Gravida 5 Para 3 at 36 weeks' estimated gestational age presents to obstetric triage with regular uterine contractions. You provide the initial cervical examination and find the patient is 6-cm dilated, 90% effaced, and 0 station. Membranes are intact. The pregnant person is admitted to labor and delivery. Hold a 1-minute brief to prepare for this situation."

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster).

After team brief, Instructor adds: "The patient calls you to report having a gush of fluid and feeling vaginal pressure. You re-examine the patient and note an umbilical cord is palpable and the cervix is 7-cm dilated. What do you do now?"

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes, Instructor says:	Expected safety behaviors:
Elevate the presenting fetal part	• How do you do that?	☐ Keep hand in vagina to elevate the fetal head off of the umbilical cord
Call for help	• What extra personnel do you need? • Anesthesia and the obstetric surgical team are in house but are in another operating room (OR) case. Estimated arrival time is 15 to 20 minutes	☐ Extra nurses ☐ Neonatal team (newborn resuscitation team) ☐ Surgical team/obstetric backup ☐ Anesthesia ☐ Request OR is prepared
Assess FHR	• Fetal heart rate is 90 BPM. What can you do now? • With interventions and your hand continuing to elevate the fetal head off the umbilical cord, the fetal heart rate (FHR) returns to 110 BPM	☐ Administers terbutaline 0.25 mg subcutaneously ☐ Patient repositioning performed ☐ Obtain intravenous access ☐ Oxygen applied ☐ Place Foley catheter and fill with 500 mL normal saline
Transport patient to OR	• What do you do while awaiting arrival of anesthesia and surgical team? • FHR now 120 BPM with variable decelerations to 90 BPM with contractions	☐ Woman transported to the OR ☐ Hand remains in vagina holding up fetal head off umbilical cord ☐ Continually assess FHR ☐ Patient prepped for cesarean delivery

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes

☐ No

Case conclusion: "The obstetric backup, surgical team, and anesthesia arrive. Anesthesia is administered and a cesarean delivery is performed. This can be performed using general anesthesia; however, if the fetus has a normal baseline heart rate with variability, then spinal analgesia is an option. A viable infant with Apgar scores of 4 and 8 is delivered."

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐Passed

☐Needs remediation

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(Instructor Signature)

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(Instructor Printed Name)

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(Date)

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Instructor Scenario Sheet

Group Testing - Case 7: Amniotic Fluid Embolism

Assigned Team Leader Name: ____

Instructor reads scenario introduction: "A 26-year-old Gravida 2 Para 1 at 40 weeks' estimated gestational age presents to the labor and delivery unit with spontaneous labor. The patient's cervix is 4 cm dilated, 100% effaced, and 0 station. The patient reports painful contractions every 2 minutes. One hour later, the cervix is 7 cm dilated, 100% effaced, and +1 station. Hold a 1-minute brief to prepare for this situation."

1. Team leader facilitates team brief (1 minute: Review of written materials acceptable, such as mnemonic card or poster).

After team brief, Instructor adds: "You enter the pregnant person's room to check in. The patient suddenly develops shortness of breath, confusion, and cyanosis, quickly followed by loss of consciousness. What do you do now?"

2. Safe Performance and Team Communication checklist (7 minutes maximum: No written materials permitted)

Leader/team should verbalize:	After leader/team verbalizes, Instructor says:	Expected safety behaviors:
Initial assessments	• The pregnant person has no pulse, is apneic and cyanotic • Fetal heart rate drops to 80 BPM	☐Calls code blue ☐Requests crash cart ☐Notes time initiated
Call for help	• Which personnel do you need?	☐Extra nurses ☐Neonatal resuscitation team on standby ☐Surgical team/obstetrical backup ☐Anesthesia staff notified
Primary survey and interventions	• What specific life support steps do you assess and address? -**C**irculation -**A**irway -**B**reathing • The crash cart has arrived at the bedside. What are some next steps?	☐Starts chest compressions immediately ☐Maintain supine position ☐Manual uterine displacement ☐Repositions airway ☐Requests bag valve mask/rescue breaths ☐Obtains intravenous (IV) access with 2 large bore IV lines ☐Places automated external defibrillator pads ☐Connects to telemetry monitor ☐All times recorded and announced by recorder at each 1-minute mark

Secondary survey and interventions	• The pregnant person is in ventricular fibrillation • After initial shock, the pregnant person is now in asystole. What do you do? • Continued asystole despite effective cardiopulmonary resuscitation (CPR) at 4 minutes. What do you do?	☐Assesses and addresses cardiac rhythm ☐Removes continuous electronic fetal monitor components ☐"Clears" and delivers shock ☐Resumes compressions ☐Considers advanced airway ☐Assesses and addresses potential causes of cardiac arrest ☐Administers advanced cardiac life support (ACLS) drug regimen as indicated ☐Repeats chest compression/shock cycle ☐All times recorded and announced by recorder at each 1-minute mark ☐Decides to perform perimortem cesarean delivery by the 4-minute mark (can be sooner if asystole continued)
Perimortem Cesarean Delivery	• You make the decision to perform a perimortem cesarean delivery in the patient's room. What supplies do you need from your crash cart to proceed? • The infant is delivered and handed off to the neonatal team for resuscitation. What do you do after delivery and manual removal of placenta?	☐Requests betadine and scalpel ☐Quickly splashes abdomen with betadine ☐Performs vertical skin incision (experienced obstetric surgeon may choose Pfannenstiel) ☐Delivers infant within a maximum of 5 minutes after initial loss of maternal circulation ☐All times recorded by recorder ☐Packs uterus with laps ☐Continues CPR throughout ☐Continues ACLS cycle ☐Notifies operating room/intensive care unit (ICU) team of transfer

Closed-loop communication was successfully performed by the team on all interventions/orders:

☐ Yes
☐ No

Case conclusion: “A viable infant is delivered with Apgar scores of 2 and 4 and admitted to the neonatal intensive care unit. After delivery of the infant, immediately resume CPR and pack the uterus. Shortly after the infant was delivered the patient was cardioverted into a sinus rhythm and transferred to the ICU for further monitoring. Laboratory evaluation was consistent with the diagnosis of amniotic fluid embolism, based on elevated prothrombin time/partial thromboplastin time levels and low fibrinogen levels.”

3. Team leader facilitates an effective team debrief (2 minutes maximum)

- What went well?
- What did not go well?
- What could we do differently next time?

Instructor evaluates team for safety and use of expected behaviors:

☐ Passed

☐ Needs remediation

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(Instructor Signature)

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(Date)

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